

<b>Case Number:</b>	CM14-0143344		
<b>Date Assigned:</b>	09/22/2014	<b>Date of Injury:</b>	01/24/2012
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	08/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Preventative Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 48 year old employee with date of injury of 1/24/2012. Medical records indicate the patient is undergoing treatment for Tenosynovitis, shoulder; shoulder joint pain. She is status post left shoulder arthroscopy (5/30/2013) Subjective complaints include left shoulder pain described as constant, throbbing or achy and burning. She has occasional tingling which is worsened with activity. Her pain radiates to the left side of her neck with tightness, throbbing and heaviness. The pain will occasionally radiate to the left upper extremity with numbness and tingling to the #1-3 fingers and occasionally the pinkies and left thumb. She has occasional headaches. A TENS unit helps relieve the pain. Objective findings include decreased range of motion, no edema, no swelling and a positive Hawkin's and Neer's test. Treatment has consisted of PT, TENS unit, Ketoprofen, Tramadol, Omeprazole and Menthoderm gel. On 12/2/2012 she had a fluoroscopic guided arthrogram of the left shoulder and status post left shoulder arthroscopy. The utilization review determination was rendered on 9/4/2014 recommending non-certification of Retro Ketoprofen 75mg #60, Retro Tramadol 50mg #90 and Retro Menthoderm Gel.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Retrospective (DOS: 8/6/14) Ketoprofen 75mg, #60: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ketoprofen, NSAIDs Page(s): 67-72. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Ketoprofen and NSAIDS

**Decision rationale:** MTUS recommends the use of NSAIDS for the acute exacerbation of back pain at the lowest effective dose for the shortest amount of time due to the increased cardiovascular risk, renal, hepatic and GI side effects associated with long term use. MTUS states "Ketoprofen 50, 75 mg, Ketoprofen ER 200 mg: Dosing: Osteoarthritis: Regular release capsule 50mg four times per day or 75mg three times per day (max 300mg/day). XR capsule 200mg once daily. Mild to moderate pain: Regular release capsule 50mg every 6 to 8 hours (Max 300mg/day)". The treating physician did not document a decrease in pain or functional improvement from the use of ketoprofen. In addition, the treating physician did not detail a trial and failure of first line NSAID medications. As such the request for Retrospective Ketoprofen 75mg, #60 is not medically necessary.

**Retrospective (DOS: 8/6/14) Tramadol 50mg, #90: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol Page(s): 74-96, 113, 123. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) - Medications for acute pain (analgesics), Tramadol (Ultram®)

**Decision rationale:** Tramadol is classified as central acting synthetic opioids. MTUS states regarding tramadol that "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." ODG further states, "Tramadol is not recommended as a first-line oral analgesic because of its inferior efficacy to a combination of Hydrocodone/ acetaminophen." The treating physician did not provide sufficient documentation that the patient has failed a trial of non-opioid analgesics at the time of prescription or in subsequent medical notes. Additionally, no documentation was provided which discussed the setting of goals for the use of tramadol prior to the initiation of this medication. As such, the request for Retro Tramadol 50mg, #90 is not medically necessary.

**Retrospective (DOS: 8/6/14) Mentherm Gel: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams

**Decision rationale:** MTUS and ODG recommend usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." As such, the request for Methoderm gel is not medically necessary.